

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Woodlawn Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 West Front Street Skowhegan, ME 04976	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, and interviews, the facility failed to ensure a resident's safety during care resulting in the resident rolling out of bed to the floor and sustaining a fractured left humerus (long bone in upper arm) for 1 of 1 resident reviewed for fall and fracture. Finding: On 7/22/26, a review of R1's clinical record was completed. Documentation in a nursing note, dated 4/25/26, a statement made by Certified Nurse Assistant #1 (C.N.A.1), indicated that while C.N.A.1 was changing R1's bed sheets, R1 rolled out of bed onto the floor. On 4/25/26, documentation made at the Emergency Department (ED) indicated the resident was seen due to a fall out of bed. Documentation in R1's active problem list indicated some of this/her problems are bipolar disorder, post traumatic stress disorder, anxiety, above the knee amputation (AKA) on left side, altered mental state, arthritis, memory loss, and unable to care for self. Documentation indicated that R1 told ED staff that his/her sheets were being changed and they had to roll over and when they did they fell over a pillow and landed on their left side. During this visit, an x-ray showed no injury to the left shoulder. On 5/15/26, twenty days after the fall out of bed, R1 was transported to the ED for complaints of abdominal pain/potential constipation. ED documentation indicated that R1 complained of hurting all over but especially the left shoulder. ED documentation indicated R1 fell out of bed 2 or 3 weeks ago and had been evaluated at this ED and no injury. On this 5/15/26 ED visit, an x-ray was done and it was discovered that R1 had a fractured left humerus. Documentation in the Physician's Progress note, dated 5/29/26, indicated previously R1 fell from bed on 4/25/26, landing on his/her left side resulting in left shoulder and elbow pain. A displaced left humerus fracture was identified by x-ray on 5/15/26. On 7/22/26 at 10:00 a.m., in an interview with the surveyor, R1 stated that a few weeks ago, they fell out of bed when rolling over for care and fractured their left shoulder. On 7/30/25 at 3:33 p.m., in a telephone interview with the surveyor, C.N.A.1. stated that R1 was a one-person assist at the time (4/25/26). R1 was able to roll over by themselves. C.N.A.1 stated she thought there was a handrail on one side of the bed but couldn't remember if there was one on the side R1 rolled toward. C.N.A.1 stated she is 5 feet 1 inch, so she did not have the bed up in a high position. C.N.A.1 stated she was going to change R1's bed sheet, and asked R1 to roll over onto his/her left side. C.N.A.1 stated before she could do anything, R1 rolled over so fast she couldn't stop R1. C.N.A.1 stated it all happened so fast and she did not remember R1 being close to the edge of the bed and did not remember if a pillow was placed between R1 and the edge of the bed. C.N.A.1 stated she is aware that R1 has an AKA on the left side, the side R1 was rolling onto too. There is no evidence in the clinical record that any safety interventions were put in place to ensure R1 did not roll off the bed prior to having R1 roll over onto the left side. There was no evidence that C.N.A.1 ensured that R1 was not too close to the edge of the bed or that a pillow or device was used to stabilize the resident when lying on their left side.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report an injury of unknown origin for a fracture identified on 5/15/26 to Licensing and Certification or Adult Protective for 1 of 1 resident reviewed for fractures. (Resident #1 [R1]).Finding: On 7/22/26, a review of R1's clinical record was completed. Documentation in a nurse note, dated 4/25/26, of a statement made by Certified Nurse Assistant #1 (C.N.A.1), indicated that while C.N.A.1 was changing R1's bed sheets, R1 rolled out of bed onto the floor. Documentation made by the Emergency Department (ED), dated 4/25/26 indicated the resident was there due to a fall out of bed. During this visit, an x-ray showed no injury to the left shoulder. On 5/15/26, R1 was transported to the ED for complaints of abdominal pain/potential constipation. During this ED visit, R1 complained of pain in the left shoulder. An x-ray was done and it was discovered that R1 had a fractured left humerus (long bone in upper arm). On 7/22/26 at 10:00 a.m., in an interview with the surveyor, R1 stated that a few weeks ago, he/she fell out of bed when rolling over for care and now has a fractured left shoulder. On 7/22/26 at 12:34 p.m., in an interview with the surveyor, the Director of Nursing (DON) stated she did not feel that the fractured left humerus discovered on 5/15/26 at the ED was related to R1's fall out of bed on 4/25/26. The DON stated that almost a month's time had passed and R1 goes out a lot to the parking lot and out with friends. The DON stated something could have happened during those times to cause the left humerus fracture. The DON stated she did not think of the fracture as an injury of unknown origin at that time the fractures was discovered and confirmed that she did not file an incident report for the injury of unknown origin with Licensing. There was no evidence in R1's clinical record that a report of an injury of unknown origin on 5/15/26 was sent to Licensing and Certification or Adult Protective.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, facility Abuse Policy review, and interview, the facility failed to ensure that an investigation was completed for an undetermined injury of unknown origin (fracture of left arm) identified on 5/15/26 for 1 of 1 resident reviewed for fractures (Resident #1 [R1]). Finding: On 7/22/26, a review of R1's clinical record was completed. Documentation in a nurse note, dated 4/25/26, of a statement made by Certified Nurse Assistant #1 (C.N.A.1), indicated that while C.N.A.1 was changing R1's bed sheets, R1 rolled out of bed onto the floor. Documentation made by the Emergency Department (ED), dated 4/25/26 indicated the resident was there due to a fall out of bed. During this visit, an x-ray showed no injury to the left shoulder. On 5/15/26, R1 was transported to the ED for complaints of abdominal pain/potential constipation. During this ED visit, R1 complained of pain in the left shoulder. An x-ray was done and it was discovered that R1 had a fractured left humerus (long bone in upper arm). R1 was transported back to the facility with a shoulder sling and instructions for a follow-up with an orthopedic. On 7/22/26 at 10:00 a.m., in an interview with the surveyor, R1 stated that a few weeks ago, when they were rolling over in order to get personal care, they rolled out of bed and fractured their left shoulder. On 7/22/26 at 12:34 p.m., in an interview with the surveyor, the Director of Nursing (DON) stated she did not feel that the fractured left humerus discovered on 5/15/26 at the ED was related to R1's fall out of bed on 4/25/26. The DON stated that almost a month's time had passed and R1 goes out a lot to the parking lot and out with friends. The DON stated something could have happened during those times to cause the left humerus fracture. The DON stated she did not think of the fracture as an injury of unknown origin for the fracture identified on 5/15/26 and confirmed that she did not do an investigation into the potential cause of the fractured left humerus. On 7/22/26, a review of the facility Resident Abuse Prevention Policy and Procedure indicated under #5 Reporting/Response; c. reports of alleged abuse, neglect or exploitation will be reported to DHS Licensing and Certification. Reports of injuries of unknown origin should be immediately reported to the Administrator. #6 Investigations; any incident which may in fact be abuse, neglect or exploitation will be logged, assigned to the Director of Nursing or the Social Service Director to investigate. A copy of the report will be sent to DHS, Licensing and Certification. On 7/22/26 at 12:34 p.m., in an interview with the surveyor, the Director of Nursing (DON) confirmed that she did not investigate the injury of unknown origin/fractured left humerus identified on 5/15/26 for potential causative factors.		